NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 14, 2003

Re:

MDR Tracking #: M2-03-0367-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

Reports available are very limited here. There are handwritten notes and a dictated report typed with the signature of ___ from ___ regarding the client. Injury date given is ___. The date of the letter was September 6, 2002 where he states that ___ being treated for rotator cuff syndrome, carpal tunnel syndrome, and tenosynovitis of the foot and ankle. She was prescribed the EMT 2000 neuromuscular stimulator for its advanced capabilities in reducing pain associated with the injury. Long term objective he states was to reduce if not alleviate the need for use of pain medication. He stated that the device should be utilized for indefinite home use. The initial assessment form was reviewed where the claimant had complaints of pain, swelling, numbness, muscle weakness, muscle stiffness, limited range of motion, and pain 8/10 in the shoulder. The history is sketchy as far as the indications or as to what exactly transpired, what was the cause of this individual's problem. There is no record to indicate whether this individual had been referred to ___ by another physician. In this handwritten hand checked report the EMT 2000 is noted as a device for home use. The settings were given two to three times per day for swelling and weakness at settings A and settings B, nine times per day, unlimited times for pain.

Requested Service(s)

Use of a neuromuscular stimulator unit

Decision

I agree with the insurance carrier that use of the stimulator is not medically necessary.

Rationale/Basis for Decision

The records that are available today do not support the use or indication for a neuromuscular stimulator. Certainly for the use of indefinite, I can see no indication and nothing in the record would indicate the need for an indefinite use of a neuromuscular stimulator. There is no noted objective atrophy in the upper extremity. There is no workup here that would support the need for a long-term of an electrical muscle stimulator. Therefore, I would not recommend authorization of this equipment on the basis of lack of objective data indicating the need for this and specifically for use of this device for an indefinite period of time.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (pre-authorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 14th day of March 2002.